



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

512-804-4000 telephone • 512-804-4811 fax • www.tdi.texas.gov

MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name and Address

ELITE HEALTHCARE NORTH DALLAS
PO BOX 1210
FRISCO TX 75034

Respondent Name

MIDWEST EMPLOYERS CASUALTY CO

Carrier's Austin Representative Box

Box Number 19

MFDR Tracking Number

M4-13-1025-01

MFDR Date Received

DECEMBER 27, 2012

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "This patient WON his Contest Case Hearing"

Amount in Dispute: \$1,671.13

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The provider's request was not received by DWC until 12/27/12. It is not timely as to any of the disputed DOS. The provider has failed to invoke the jurisdiction of DWC MRD as to these dates."

Response Submitted by: Flahive, Ogden & Latson, PO Drawer 201320, Austin, TX 78720

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
November 13, 2009 through October 11, 2011	Office Visits and Physical Therapy,	\$1,671.13	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

- 28 Texas Administrative Code §133.307 sets out the procedures for health care providers to pursue a medical fee dispute.
- The services in dispute were reduced/denied by the respondent with the following reason codes:
 - 214 – Workers' compensation claim adjudicated as non-compensable. This payer not liable for claim or service/treatment.
 - (16) – Claim/service lacks information which is needed for adjudication.
 - (18) – Duplicate claim/service.
 - BL – To avoid duplicate bill denial, for all recon/adjustments/additional pymt request, submit a copy of this EOR or clear notation that a rec

- 29 – The time limit for filing has expired.
- W1 – Workers Compensation State Fee Schedule Adjustment.
- 97 – Payment is included in the allowance for another service/procedure.
- 4 – Procedure code is inconsistent with the modifier used or a required modifier is missing.

Issue

1. Did the requestor waive the right to medical fee dispute resolution?

Findings

28 Texas Administrative Code §133.307(c)(1) states: "Timeliness. A requestor shall timely file with the Division's MDR Section or waive the right to MDR. The Division shall deem a request to be filed on the date the MDR Section receives the request. (A) A request for medical fee dispute resolution that does not involve issues identified in subparagraph (B) of this paragraph shall be filed no later than one year after the date(s) of service in dispute." The dates of the service in dispute are November 3, 2009 through October 11, 2011. The request for medical dispute resolution was received in the Medical Dispute Resolution (MDR) section on December 27, 2012. This date is later than one year after the date(s) of service in dispute. Review of the submitted documentation finds that the disputed services involve issues identified in §133.307, subparagraph (B), which states in part, "a request may be filed later than one year after the dates of service if a related compensability, extent of injury, or liability dispute under Labor Code Chapter 410 has been filed, the medical fee dispute shall be filed not later than 60 days after the date the requestor receives the final decision, inclusive of all appeals, on compensability, extent of injury, or liability." Review of the Contested Case Hearing Decision and Order finds this decision was signed by the Hearing Office on April 6, 2010. The Division concludes that the requestor has failed to timely file this dispute with the Division's MDR Section; consequently, the requestor has waived the right to medical fee dispute resolution.

Conclusion

The Division finds that the requestor has waived the right to medical fee dispute resolution for the services in dispute. For that reason, the merits of the issues raised by both parties to this dispute have not been addressed.

Authorized Signature

<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Signature	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> Medical Fee Dispute Resolution Officer	<hr style="border: 0; border-top: 1px solid black; margin-bottom: 5px;"/> October 21, 2013 Date
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YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.